COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 525
LOS ANGELES, CALIFORNIA 90012-2766
PHONE: (213) 974-8301 FAX: (213) 626-5427

J. TYLER McCAULEY
AUDITOR-CONTROLLER

March 4, 2003

TO: Supervisor Yvonne Brathwaite Burke, Chair
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: J. Tyler McCauley
Auditor-Controller

SUBJECT: **DEPARTMENT OF CHILDREN AND FAMILY SERVICES REVIEW OF INTERNAL AFFAIRS DIVISION – PHASE II**

On April 16, 2002, your Board directed the Auditor-Controller to evaluate all divisions within DCFS that investigate child deaths and serious injuries; analyze the different types of child death and serious incidents currently reported to the Board; and develop a format(s) for reporting child deaths and serious injuries to provide appropriate and meaningful information to the Board.

Our office incorporated this request into the second phase of our review of the Department's Internal Affairs Division, which we had initiated at the request of the former DCFS Director. Our first phase report focused on an analysis of the Division's case tracking systems, as well as a determination of the Division's backlog of cases, by case type and age.

METHODOLOGY

As part of our review, we interviewed all Internal Affairs/Civil Rights & Affirmative Action staff, and other staff from the Child Abuse Hotline, the Bureau of Child Protection (BCP), the Bureau of Children and Family Services (BCFS) and the Quality Assurance Division. We reviewed child death and serious incident logs that each of these units maintains, and reviewed a sample of cases investigated. Finally, we interviewed management of Internal Affairs units in five other County departments (Fire, Health Services, Probation, Public Social Services and Public Works.)

KEY FINDINGS

We observed that DCFS' process for investigating child deaths and serious injuries reported to the Department's Child Protection Hotline is spread among five different

units (i.e., BCP, BCFS, Internal Affairs, Quality Assurance, Serious Incident Analysts.) BCP and BCFS generally conduct the investigations themselves, and only refer cases to Internal Affairs when evidence exists of staff misconduct. The Serious Incident Analyst position, reporting to the Executive Office, was established by the former Director to quickly identify and gather facts on child deaths and serious incidents. The Quality Assurance Division investigates the licensed caregiver involved in the allegation to assess the Department's future use of the caregiver.

In general, the current investigation process is cumbersome, inefficient and confusing. The deficiencies we identified in the current process include:

1. **The Bureaus (BCP and BCFS) generally conduct investigations of child deaths and serious incidents themselves. The investigations are, for the most part, not conducted by an independent, unbiased unit (Internal Affairs).** Internal Affairs' role is limited to the investigation of matters that the Bureaus refer, or matters that Internal Affairs independently determines constitute "egregious" employee misconduct. However, we found that Internal Affairs has not established a clear definition of the type of circumstances that constitute an "egregious" matter, nor does it conduct timely and documented preliminary assessments to determine if the circumstances of the case meet a pre-defined type or manner of possible misconduct so as to warrant a formal investigation.

2. **There is confusion among the Units regarding investigation responsibility.** Staff with whom we spoke stated the confusion over individual unit responsibilities has evolved over the last 12 to 18 months with the creation of the BCP; creation of the Serious Incident Analyst position under the Executive Office; and frequent staff and management rotations. These circumstances have at times resulted in duplication of work and lack of accountability.

3. **The Department does not maintain a central tracking system to ensure that all serious incidents and child deaths are investigated in a timely, complete and well-documented manner.** As well, the Department is unable to easily provide concerned stakeholders with statistics regarding the number or types of investigations. This has led to some concern that the Department is "hiding" child deaths or serious incidents from its stakeholders.

4. **The Department lacks documented policies and procedures for investigating serious incidents and child deaths.** Lack of policies and procedures provides no assurance that investigations are completed in a uniform, thorough and well documented manner.

5. **The reporting of the results of the investigations of child deaths and serious incidents is inconsistent among the investigating units, in terms of frequency, content, and distribution**. For example, the Child Fatality Alert notices that the Department sends to the Board do not contain pertinent

information (i.e., case name, child name, age or location of the incident). Additionally, the Department's Serious Incident Logs are routed in an ad hoc manner to the Board through the Commission for Children and Families.

6. **The Department does not maintain a central filing or record keeping system of its investigation files and reports.** Not all investigating units maintain orderly and complete investigation files. For example, BCFS could not locate two of the 10 client case files that we requested to review. Additionally, the "central" filing location for reports to the Board was disorganized and incomplete.

7. **The Department does not formally monitor the status of any corrective actions identified in its investigations.** Corrective actions that result from an investigation could include changes in policy or the discipline of an employee. However, the Department does not formally monitor these corrective actions to ensure the responsible party implements the corrective action in a timely manner.

RECOMMENDATIONS

The Department needs to consolidate responsibility for investigations and investigation oversight into the Internal Affairs Unit, as shown in the chart below. Centralizing the investigations and their oversight in Internal Affairs will ensure that investigations will be conducted by an independent, unbiased party and will provide central accountability for all cases. As well, centralization will ensure that the Department investigates and reports on all matters in a uniform, timely and well documented manner; and that it develops and monitors corrective actions.

<table>
<tr><th>Current Investigation Process</th><th colspan="2">Recommended Investigation Process</th></tr>
<tr><td>Child Protection Hotline
↓</td><td colspan="2">Child Protection Hotline
↙ ↘</td></tr>
<tr><td>"Investigation and Reporting"
↓</td><td>"Investigation and Reporting"
↓</td><td>"Administrative Review"
↓</td></tr>
<tr><td>• Bureau of Child Protection (BCP)
• Bureau of Children and Family Services (BCFS)
• Internal Affairs
• Serious Incident Analyst
• Quality Assurance</td><td>Internal Affairs</td><td>• Bureau of Child Protection (BCP)
• Bureau of Children and Family Services (BCFS)
• Quality Assurance</td></tr>
</table>

In this recommended investigation model, BCP and BCFS should continue to perform an administrative review to evaluate service issues (e.g., if there are other children in the home, and if they should be removed; if the Department should alter services for the

child or family.) However, the Bureaus must be careful not to expand their administrative reviews into investigations.

We found that the Internal Affairs Division is appropriately placed under the Department's Executive Office. This reporting structure maintains the appropriate level of necessary independence for an Internal Affairs unit at a child welfare agency. However, we found that the Division's Civil Rights and Affirmative Action section is better placed under Human Resources, as Human Resource divisions in the County are typically responsible for allegations of discrimination, retaliation or violations of State or federal employment laws. This section previously reported under Human Resources prior to Spring 2001 when the former Director transferred it to Internal Affairs.

Regarding staffing, we found the Department currently utilizes three distinct classification series to staff its Internal Affairs section, none of which is an investigator series. The Department should conduct a classification study to determine the appropriateness of utilizing an investigator series to staff Internal Affairs. At minimum, the IA section (Unit) head should be very experienced in the investigatory function.

REVIEW OF REPORT

We discussed our report with Department management who generally agreed with its findings and recommendations. Subsequent to the completion of our fieldwork, the Department began to develop a corrective action plan to address the deficiencies we identified. We reviewed the Department's plan with them on February 11, 2003 and it accomplishes the important objectives of consolidating the responsibility for investigations and reporting under an office distinct from the service Bureaus. The Department's response to the report is attached.

We thank DCFS management and staff for their cooperation and assistance during our review. If you have any questions regarding this report, please contact me or have your staff contact DeWitt Roberts at (626) 293-1101.

JTM:DR:JK
Attachments

c: David E. Janssen, Chief Administrative Officer
Lloyd W. Pellman, County Counsel
Marjorie Kelly, Interim Director, Department of Children and Family Services
Violet Varona-Lukens, Executive Officer
Commission for Children and Families
Audit Committee
Public Information Office

Los Angeles County

Department of Children and Family Services

Review of Internal Affairs Division – Phase II

March 2003

Prepared by:

Department of Auditor-Controller

SCOPE AND OBJECTIVES 1

METHODOLOGY 1

BACKGROUND 1

COMMENTS AND RECOMMENDATIONS 1

Reporting and Investigating Suspected Child Abuse Cases 1
Investigating Units 2
Deficiencies in the Investigation Process 3
Reconciliation of Child Deaths and Serious Incidents 5

Recommended Investigation Process Model 5
Investigation Types 5
Development and Monitoring of Corrective Action 7
Other Issues 8

Reporting to the Board of Supervisors 8
Consolidation of Reporting Responsibilities 8
Reporting Formats 9
Reporting Deaths and Serious Incidents 10

Organizational Structure 11
Organizational Placement 11
Staffing 12

Follow-up to Phase I Recommendations 13

Department of Children and Family Services
Review of Internal Affairs Division – Phase II

SCOPE AND OBJECTIVES

The Board directed the Auditor-Controller to evaluate all divisions within DCFS that investigate child deaths and serious injuries; analyze the different types of child death and serious incidents currently reported to the Board; and develop a format(s) for reporting child deaths and serious injuries to provide appropriate and meaningful information to the Board. Our office incorporated this request into the second phase of our review of the Department's Internal Affairs/Civil Rights & Affirmative Action Division (Division), which we had initiated at the request of the former DCFS Director. Our first phase report focused on an analysis of the Division's case tracking systems, as well as a determination of the Division's backlog of cases, by case type and age.

METHODOLOGY

As part of our review, we interviewed all Internal Affairs/Civil Rights & Affirmative Action staff, and other staff from the Child Abuse Hotline, the Bureau of Child Protection, the Bureau of Children and Family Services and the Quality Assurance Division. We reviewed child death and serious incident logs that each of these units maintains, and reviewed a sample of cases investigated. Finally, we interviewed management of Internal Affairs units in five other County departments (Fire, Health Services, Probation, Public Social Services and Public Works.)

BACKGROUND

The Division consists of two sections: Internal Affairs and Civil Rights & Affirmative Action. The Internal Affairs section stated mission is to investigate allegations of egregious staff misconduct. The Civil Rights & Affirmative Action section investigates civil rights, disability, sexual harassment, discrimination and employee retaliation allegations. The Division currently reports to DCFS' Interim Director. The Division is budgeted for fourteen investigator and four support staff positions. The Division is only one of five distinct units within the Department that investigate, to some extent, child death and serious incidents. The other units are BCP and BCFS, Serious Incident Analysts and the Quality Assurance Division.

COMMENTS AND RECOMMENDATIONS

Reporting and Investigating Suspected Child Abuse Cases

The California Penal Code requires certain professionals and laypersons who have a special relationship or contact with children to report suspected abuse or neglect to a child protective agency immediately, or as soon as practically possible. These "mandated reporters" include childcare providers, health practitioners, firefighters, clergy members and employees of a child protective agency, among others.

The reporting law is also designed to ensure that law enforcement and child welfare agencies and district attorneys receive and review reports, whether initially reported to them, or to another agency. Specifically, the California Penal Code requires that county child welfare agencies cross-report to local law enforcement and district attorney offices, reports of child abuse, except for reports involving general neglect. Conversely, law enforcement is also required to cross-report immediately, or as soon as possible, to child welfare agencies and the district attorney office.

Investigating Units

The DCFS Child Protection Hotline (Hotline) serves as a call center for reports of suspected child abuse or neglect within Los Angeles County. When the Hotline receives an allegation of a death or serious incident[1], due to abuse or neglect, and the child/family are known to the Department, or have had prior services, the Hotline distributes a notification to at least five other DCFS units for investigation and/or review.

The investigating units in the Department and their roles in the investigation process are outlined below. (See Attachment I.)

1. **The Bureau of Child Protection (BCP)**: This Bureau's emergency response workers investigate allegations of abuse or neglect on open or closed referrals and on open cases after normal business hours. BCP conducts a cursory review, immediately or within five business days of notification from the Hotline, primarily to ensure child safety and to determine whether the allegation of abuse or neglect actually occurred as reported. BCP has up to 30 days to conclude its administrative review, by closing out the case, transferring the case to the regular case worker for continued services, or filing a petition with the court to detain the child. BCP also prepares a "fact sheet" for Bureau management, within several days of receipt of the allegation, and, in the case of child fatalities, a comprehensive report of its investigation to the Board within 30 days.

2. **The Bureau of Children and Family Services (BCFS)**: The Regional Administrators (RA), Assistant Regional Administrator (ARA) and Supervising Children's Social Worker (SCSW) investigate all serious incidents and child deaths resulting from suspected abuse or neglect on open cases to determine whether the children's social worker followed Departmental policy and procedure to ensure child safety, to provide all necessary and/or court-ordered services and resources to the child and family, and to identify possible incidences of employee misconduct/negligence. If BCFS suspects employee wrongdoing, it refers these cases to Internal Affairs for investigation. BCFS prepares a fact sheet within 24 hours of the reported allegation, a report of its administrative review to RAs and

[1] The Department currently defines a serious incident (non-death) as serious injuries that result in substantial medical problems and hospitalization (due to abuse or neglect), media cases, serious exploitation, suicide attempts resulting in hospitalization, all abandoned infants or children and all kidnappings from out of home care facilities.

Bureau Chiefs within 10 days, and, in the case of child fatalities, a comprehensive report to the Board within 30 days.

3. **Internal Affairs Division:** Staff in this Division investigate "egregious" employee misconduct; conduct that may lead to criminal acts beyond departmental policy violations. Internal Affairs staff prepares a written report of their investigation process and submits this report to the DCFS director. There are no established timeframes in which Internal Affairs conducts its investigation or reports its results to the Director.

4. **Serious Incident Analyst:** The former Director created the Serious Incident Analyst position in June 2001, which reported to the Executive Office. The former Director established the position to quickly identify and gather facts on child deaths and other serious incidents. The Department currently staffs three Serious Incident Analyst positions that report to the bureau directors of BCP and BCFS. The Analysts are responsible for assisting the bureaus in their administrative reviews and investigations.

5. **The Out of Home Care Evaluation Unit (OHCEU)**: The OHCEU is assigned to the Bureau of Administration's Quality Assurance Division. Staff in this Unit investigate allegations of suspected abuse/negligence by the licensed caregiver and assess the Department's future use of the facility. OHCEU can recommend that a licensed caregiver be put on a *Do Not Use* or *Do Not Refer* operational status. Typically, OHCEU investigators respond to allegations within ten business days.

Finally, although not an investigating unit, the Department's Human Resources Division's Performance Management Unit consults with Bureau management regarding the imposition of disciplinary action when an employee's work performance or conduct violates Department or County policy.

Deficiencies in the Investigation Process

We noted a number of significant deficiencies in the above-outlined investigation process. Specifically:

1. **The Bureaus (BCP and BCFS) generally conduct investigations of child deaths and serious incidents themselves. The investigations are, for the most part, not conducted by an independent, unbiased unit (Internal Affairs).** Internal Affairs' role is limited to the investigation of matters that the Bureaus refer, or matters that Internal Affairs independently determines constitute "egregious" employee misconduct. However, we found that Internal Affairs has not established a clear definition of the type of circumstances that constitute an "egregious" matter, nor does it conduct timely and documented preliminary assessments to determine if the circumstances of the case meet a

pre-defined type or manner of possible misconduct so as to warrant a formal investigation.

2. **There is confusion among the Units regarding investigation responsibility.** Staff with whom we spoke stated the confusion over individual unit responsibilities has evolved over the last 12 to 18 months with the creation of the BCP; creation of the Serious Incident Analyst position under the Executive Office; and frequent staff and management rotations. These circumstances have at times resulted in duplication of work and lack of accountability.

3. **The Department does not maintain a central tracking system to ensure that all serious incidents and child deaths are investigated in a timely, complete and well-documented manner.** As well, the Department is unable to easily provide concerned stakeholders with statistics regarding the number or types of investigations. This has led to some concern that the Department is "hiding" child deaths or serious incidents from its stakeholders.

4. **The Department lacks documented policies and procedures for investigating serious incidents and child deaths.** Lack of policies and procedures provides no assurance that investigations are completed in a uniform, thorough and well documented manner.

5. **The reporting of the results of the investigations of child deaths and serious incidents is inconsistent among the investigating units, in terms of frequency, content, and distribution**. For example, the Child Fatality Alert notices that the Department sends to the Board do not contain pertinent information (i.e., case name, child name, age or location of the incident). Additionally, the Department's Serious Incident Logs are routed in an ad hoc manner to the Board through the Commission for Children and Families. Further, entries on the Logs often lack basic information such as the type of serious injury or the disposition of investigation findings.

6. **The Department does not maintain a central filing or record keeping system of its investigation files and reports.** Not all investigating units maintain orderly and complete investigation files. For example, BCFS could not locate two of the 10 client case files that we requested to review. Additionally, the "central" filing location for reports to the Board was disorganized and incomplete.

7. **The Department does not formally monitor the status of any corrective actions identified in its investigations.** Corrective actions that result from an investigation could include changes in policy or the discipline of an employee. However, the Department does not formally monitor these corrective actions to ensure the responsible party implements the corrective action in a timely manner.

Reconciliation of Child Deaths and Serious Incidents

In light of the significant concerns noted in the investigation process, we attempted to determine if the Department investigated all child deaths and serious incidents resulting from abuse and neglect that the Hotline received in calendar year 2001. We requested that the Hotline provide us with a listing of all allegations of child deaths and serious incidents that it issued to each of these units for investigation in calendar year 2001 and compared this to the actual investigations each unit conducted.

We found that BCP and BCFS investigated all the child deaths that each should have investigated. However, we were unable to reconcile the investigation of serious incidents with any degree of certainty because of significant deficiencies in the manner in which the various units tracked this information. For example, some units track by the minor's name, others track by the mother's name, while yet others track by the Hotline notification identification number.

Recommended Investigation Process Model

We have concluded that significant deficiencies exist in DCFS' process of investigating child deaths, serious incidents, and other matters. To address these deficiencies, we recommend that DCFS consolidate responsibility for investigations and investigation oversight in Internal Affairs. Centralizing the investigations and their oversight in Internal Affairs will ensure that investigations will be conducted by an independent, unbiased party and provide central accountability for all cases. As well, centralization will ensure the Department investigates and reports on all matters in a uniform, timely and well documented manner, and that it develops and monitors corrective actions.

The following is an outline of this model, which addresses the types of investigations, and the development and monitoring of corrective actions. (See Attachment II.)

Investigation Types

- **Child Deaths**

  Internal Affairs should be the only unit responsible for investigating child deaths. The Hotline should continue to report incidents of child deaths and serious incidents to BCP, BCFS, Internal Affairs and OCHEU. Upon receipt of the Hotline notification, BCP and BCFS should continue to perform an administrative review to evaluate service issues (e.g., if there are other children in the home, and if they should be removed; if the Department should alter services for the child or family.) The Bureaus must be careful not to expand their administrative reviews into investigations. The Department should abolish the role of the Serious Incident Analyst, presently reporting under the Bureaus, as the position is duplicative of an Internal Affairs responsibility. Internal Affairs should also establish specific and documented policies and procedures for the investigation of child deaths.

Recommendations

DCFS management:

1. **Require Internal Affairs to investigate all child deaths.**

2. **Abolish the role of the Serious Incident Analyst, presently reporting under the Bureaus, as the position is duplicative of an Internal Affairs responsibility.**

3. **Require Internal Affairs to establish documented policies and procedures for the investigation of child deaths.**

- **Serious Incidents and Other Case Types**

Considering staffing resources and case volumes, it may not be feasible, nor necessary, for Internal Affairs to investigate all serious incidents (e.g., a child in foster care is accidentally hit by a car) or other case types (e.g., an employee files a false mileage claim.) In cooperation with Bureau management, Internal Affairs should develop specific criteria for those serious incidents and other case types that the Bureaus could investigate themselves. Internal Affairs should perform a timely and documented preliminary assessment of the matter to determine if it meets the criteria for referral to the Bureau. In addition, Internal Affairs should develop written policies and procedures for the Bureaus to follow in conducting the investigations and reporting the results. Internal Affairs should review the Bureau's investigation, upon completion, to ensure it meets established standards.

As previously discussed, DCFS does not maintain a central filing or recordkeeping system of its investigation files and reports. In this model, Internal Affairs would be responsible for maintaining a central database of all investigations and a central investigation filing system.

Recommendations

DCFS management:

4. **Require Internal Affairs, in cooperation with Bureau management, to develop specific criteria for those serious incidents and other case types that the Bureaus could investigate themselves.**

5. **Require Internal Affairs to perform a timely and documented preliminary assessment of serious incidents and other case types to determine if the matter meets the criteria for referral to the Bureau.**

6. **Require Internal Affairs to develop written policies and procedures for the Bureaus to follow in conducting the investigations and reporting the results.**

7. **For those matters which the Bureaus investigate, require Internal Affairs to review the investigation, upon completion, to ensure it meets established standards.**

8. **Require Internal Affairs to develop and maintain a central database of all investigations and a central investigation filing system.**

Development and Monitoring of Corrective Action

The Department does not consistently include corrective action plans, including a timeline for implementation, in its reports to the Board, nor is there an independent monitoring of the status of the corrective action plans.

In the proposed investigation model, Internal Affairs should present the findings of investigations to the Bureaus and to the Human Resources' Performance Management Section. The Bureaus, in consultation with Performance Management, should develop corrective actions when necessary. For child deaths and serious incidents, Internal Affairs should include the corrective actions, including a timeline for implementation, in its comprehensive report to the Board. To ensure the Department is implementing corrective actions, DCFS management should require the Department's Quality Assurance Division to formally monitor these corrective actions on a quarterly basis and issue a report on the implementation status to the Director and Board.

Recommendations

DCFS management:

9. **Require Internal Affairs to present the findings of its investigations to the Bureaus and Performance Management.**

10. **Require the Bureaus, in consultation with Performance Management, to develop corrective actions when necessary.**

11. **Require Internal Affairs to include the corrective actions, including a timeline for implementation, in its comprehensive report to the Board.**

12. **Require the Department's Quality Assurance Division to formally monitor these corrective actions on a quarterly basis and issue a report on the implementation status to the Director and Board.**

Other Issues

When reviewing the centralization of investigation responsibilities in Internal Affairs with staff, staff stated that they have historically viewed Internal Affairs as a "Gestapo" or unit that employed underhanded or unfair methods in its investigations. Staff expressed concern that consolidation of investigation responsibilities under Internal Affairs as we have proposed in this model would result in a return of this culture. The leadership of Internal Affairs must be sensitive to this historic perception and ensure that the Division consistently strives to conduct itself in a professional, fair and consistent manner.

Recommendation

13. Staff in the Internal Affairs Division consistently strive to conduct themselves in a professional, fair and consistent manner.

We also found that the Internal Affairs currently shares office space with five other distinct DCFS units (Board Relations, Labor Relations, Public Affairs, Alternate Dispute Resolutions) which may compromise its ability to maintain the confidentiality of investigations, particularly with in-person and telephone interviews. Management stated that they plan to move to a more private, secure location at the beginning of 2003. Management should ensure this move occurs as soon as possible.

Recommendation

14. DCFS management ensure that Internal Affairs moves to a more private, secure location as soon as possible.

Reporting to the Board of Supervisors

BCP and BCFS prepare Child Fatality Alert notices which they send to the Board within 24 hours of receiving a report of a child fatality. BCP and BCFS also send the Board comprehensive reports of their investigations of child fatalities, generally within 30 days of receiving a report through the Hotline. Finally, BCP and BCFS prepare a serious incident log, which is distributed to the Commission for Children and Families on an ad-hoc basis.

Consolidation of Reporting Responsibilities

BCP and BCFS are currently responsible for preparation and distribution of the 24 hour child fatality alert, 30 day comprehensive reports and serious incident logs. However, to ensure consistency of report format, distribution and content, the Department should consolidate responsibility for all reporting of investigations to the Board under Internal Affairs.

Recommendation

15. DCFS management consolidate the responsibility for all reporting of investigations to the Board under Internal Affairs.

Reporting Formats

We reviewed the reporting formats of the 24 hour Child Fatality Alert, 30 day comprehensive reports and serious incident logs to ensure they provided pertinent information in a reader friendly format. We found that DCFS can improve the reporting format of the information it sends to the Board. For example, the Child Fatality Alert does not contain pertinent information (e.g., case name, child's name, age, circumstances and location of the incident, and the Internal Affairs assignment number). The Department stated that this information is not included because the Alert is sent to many recipients and the confidentiality of the case must be maintained. However, the Department should revise the format of the Child Fatality Alert to include the pertinent information and limit the distribution of the more detailed Alert solely to the Board.

In addition, we found that the 30 day, comprehensive reports are not reader-friendly and do not contain an Executive Summary. The Department should revise the format of the comprehensive report to be consistent to that used by the Children Service's Inspector General. This format should include an Executive Summary of the case information, findings and recommendations, corrective actions and the Internal Affairs assignment number. Additionally, for investigations of child deaths, the Department should establish a reporting deadline of 60 days, as the Coroner's report is generally available within that timeframe.

Finally, we found the Serious Incident Log does not include pertinent information such as the Internal Affairs assignment number, type of serious injury, the case number, the status of the investigation, and the status of any disciplinary and/or corrective action. The Department should revise the format of the Log to include this pertinent information. We also noted that the Department does not distribute the Log to the Commission for Children and Families on a consistent basis. When requested, the Commission forwards the Log to the Board of Supervisors. The Department should distribute this Log to both the Board and the Commission on a quarterly basis.

Recommendations

DCFS management:

16. DCFS management revise the format of the Child Fatality Alert sent to the Board to include pertinent information (e.g., case name, child's name, age, circumstances and location of the incident, and the Internal Affairs assignment number.)

17. **Revise the format of the comprehensive report to be consistent to that used by the Children Service's Inspector General.**

18. **In the case of child deaths, establish a reporting deadline of 60 days, as the Coroner's report is generally available within that timeframe.**

19. **Revise the format of the Serious Incident Log to include pertinent information (e.g., the Internal Affairs assignment number, type of serious injury, the case number, the status of the investigation, and the status of any disciplinary and/or corrective action.)**

20. **Distribute the Serious Incident Log both to the Board and the Commission for Children and Families on a quarterly basis.**

Reporting Deaths and Serious Incidents

We also reviewed the Department's compliance with the April 2002 Board motion that required the Department to report to the Board on all child deaths if the child was under the care of the Department, or if the child's family had prior contact with the Department.

In the Spring 2001, DCFS established a policy of notifying the Board of children who died under the Department's care when the child: 1) had an open referral or case; or 2) the child's death occurred within one year of a referral or case that was closed, and the death was either suspected or confirmed to be due to child abuse or neglect. The Department also separately reported serious incidents[1] to the Commission of Children and Families (Commission) through the Child Death/Serious Incident Log (Log), which the Commission forwards to the Board upon request.

In April 2002, the Board directed DCFS to begin to report on all child deaths, including those that result from non-abuse or neglect, if the child was under the care of the Department, or if the child's family ever had prior contact with the Department (e.g., the child may have been in foster care at one time and then re-united with the family.) Examples of deaths that result from non-abuse or neglect include:

- Accidental (e.g., car accidents and drownings)
- Natural (e.g., still born, sudden infant death syndrome, extreme prematurity)
- Homicide (e.g., drive by shootings)
- Suicide
- Substance abuse
- Diseases (e.g., AIDS, diabetes, cancer)

[1] As previously noted, the Department currently defines a serious incident (non-death) as serious injuries that result in substantial medical problems and hospitalization (due to abuse or neglect), media cases, serious exploitation, suicide attempts resulting in hospitalization, all abandoned infants or children and all kidnappings from out-of-home care facilities.

In response to the April 2002 Board directive, the Hotline, upon receipt of a child fatality referral due to either abuse and neglect or non-abuse and neglect, searches the Department's records to determine if the child is under the care of the Department or if the child's family ever had prior contact with the Department and reports to the Board accordingly. The Department stated that the investigation and reporting of all deaths, regardless of cause and extent of the decedent's history with the Department, is laborious and time consuming and may not provide useful information. Accordingly, in conjunction with the Board, the Department should establish more detailed parameters around the April 16, 2002 Board motion.

Finally, it is important to note that, as previously discussed, the California Penal Code does not require persons to report child deaths that result from non-abuse or neglect through the Hotline. Accordingly, the Department can only report to the Board those deaths of which it is aware and those that are reported to the Department.

Recommendation

21. In conjunction with the Board, the Department establish more detailed parameters around the April 16, 2002 Board motion.

Organizational Structure

Organizational Placement

The Internal Affairs Division currently reports to DCFS' Interim Director. With the exception of the Division's Civil Rights & Affirmative Action section, this reporting relationship is consistent with the reporting structure we found at other County departments that have internal affairs units. It places the Internal Affairs Division in a very visible role in the Department and signifies the importance assigned to the Division's activities. Accordingly, we conclude that the Division's organizational placement within DCFS is appropriate.

However, we found that the Civil Rights & Affirmative Action section should report under the Department's Human Resources Division. We reviewed the Civil Rights & Affirmative Action sections at other County departments and noted that Human Resources was usually responsible for the investigation of employee complaints or allegations of discrimination, retaliation, and violations of State or federal employment laws. DCFS management should transfer the Civil Rights & Affirmative Action section from the Internal Affairs Division to the Department's Human Resources Division.

Recommendation

22. DCFS management transfer the Civil Rights & Affirmative Action section from the Internal Affairs Division to the Department's Human Resources Division.

Staffing

The Department should consider utilizing an investigator classification to staff Internal Affairs. Staff in this personnel classification are responsible for conducting investigations, serving legal process, interviewing witnesses and appropriate parties, preparing official departmental reports and occasionally testifying in court. The Department currently utilizes three distinct personnel classifications to staff Internal Affairs: Administrative Service Manager (ASM), Children Social Worker (CSW), and Human Services Administrator (HSA). The functional duties of these personnel classifications generally include performing social service administrative or policy analysis functions and do not align with Internal Affairs' investigation responsibilities. Based on our observations, review of investigation work processes, and the comments of senior managers with whom we spoke, some of the present staff, including the Division's manager, do not possess the broad range or depth of skills necessary to meet the significant challenges facing the Division.

The minimum requirements for an investigator classification include possession of a Bachelor's Degree and a paralegal certificate. These requirements would not restrict the Department from broadening the backgrounds of its investigative staff. While social work is an important skill to have represented, other skills such as auditing, paralegal, law enforcement and human resources are equally important. For example, in the investigation of a child death, investigators may have to follow an audit trail in CWS/CMS, interview law enforcement, or document certain aspects of the case for eventual consideration by the Civil Service Commission. The managers of the other Los Angeles County Internal Affairs units with whom we spoke stated that they had a broad skill set represented among their staff and that this was an integral factor in completing thorough, timely and well-documented investigations. Finally, utilization of just one personnel classification, as opposed to several distinct classifications, allows for greater consistency among staff in terms of salary and qualifications, and the development of a definitive career track.

Department management should instruct its Human Resources Division to conduct a classification study to determine the appropriateness of utilizing an investigator classification to staff its Internal Affairs Division. After completion of the study, management should review the qualifications of its present staff to ensure staff meet the qualifications of the position and that staff with diverse backgrounds are represented.

Implementation of these human resource recommendations is crucial to the successful implementation of the recommended investigation model.

Recommendations

DCFS management:

23. **Instruct its Human Resources Division to conduct a classification study to determine the appropriateness of utilizing an investigator classification to staff Internal Affairs.**

24. **After completion of the study, review the qualifications of present staff to ensure staff meet the qualifications of the position and that staff with diverse backgrounds are represented.**

Training

The Division's manager and staff stated that the Division does not have a formal training plan or a training budget. Training is given on an ad hoc, as opposed to a strategic basis. Management should conduct a formal needs assessment to determine and prioritize the necessary training for its staff. Management should then request funding for its training program in its annual budget request.

Recommendation

25. **DCFS management conduct a formal needs assessment to determine and prioritize the necessary training for its staff, and request funding for the resulting training program in its annual budget request.**

Follow-up to Phase I Recommendations

The first phase of our review focused on an analysis of the Internal Affairs Division's case tracking system, as well as a determination of the Division's backlog of cases, by case type and age. In our report, issued April 4, 2002, we found the Division maintained case listings in different formats, in either Microsoft Excel or Microsoft Word, neither of which constituted a database. Because the case information was not in a database, there was no ability to develop automated management reports. For example, management was not able to easily sort and analyze case data by assignment type, investigator, length of time the case had been open, or referral source. As well, we found the Division did not utilize a time management system. Investigators did not allocate their daily work hours to each of their open cases, thereby enabling management to establish time standards by case type and a time accountability mechanism for investigators.

During our review, management stated it had implemented an automated case management system, programmed in Microsoft Access. As this system is integral to management's ability to manage its business, we requested a demonstration of the system. The system, which is shared by investigator staff through the Division's local area network, was developed by a consultant over an eight week period. Generally, we

were impressed with the system's controls, and its ability to track and report on case activity and workload. However, we noted two areas for improvement.

- While the system requires investigators to track the hours spent on investigative tasks, the system does not require the investigators to account for all hours in a given work day. To increase the integrity of the system's time accountability component, management should enhance the system to require staff to account for all hours during their work day.

- The consultant established a limited number of management reports, but the Division will likely need to establish additional reports and/or conduct database queries through the use of Microsoft Access. The consultant stated that staff's knowledge of Microsoft Access is limited. Management should require staff to obtain training on the report writing and query functions of Microsoft Access.

Recommendations

DCFS management:

26. Enhance the Internal Affairs Division's automated case management system to require staff account for all hours in a given work day.

27. Train staff on the report writing and query functions of Microsoft Access.

Current Investigation Model

Attachment I

Mandated Reporters

Any other person

Child Protection Hotline (Hotline)

- Receive reports of suspected abuse or neglect.
- Indentify deaths and serious incidents.
- Submit 24-hr Child Fatality
- Alert to Board of Supervisors (BOS).
- Cross report to law enforcement or DCFS investigative units.

Bureau of Children and Family Services (BCFS)

- Receive report from Hotline.
- Provide front-end and back-end service to ensure child safety.
- Investigate all serious incidents and child deaths on open cases.
- Submit 30-day reports to BOS.
- Refer cases to IA as appropriate when its investigation uncovers suspected employee misconduct.

Bureau of Child Protection (BCP)

- Receive report from Hotline.
- Ensure child safety.
- Investigate allegations of abuse or neglect on open or closed referrals and on open cases after normal business hours.
- Submit 30-day report to BOS.
- Refer cases to IA, as appropriate, when its investigation uncovers suspected employee misconduct.

Internal Affairs (IA)

- Receive report from Hotline or BCFS, BCP and QA.
- Investigate "egregious" employee misconduct.

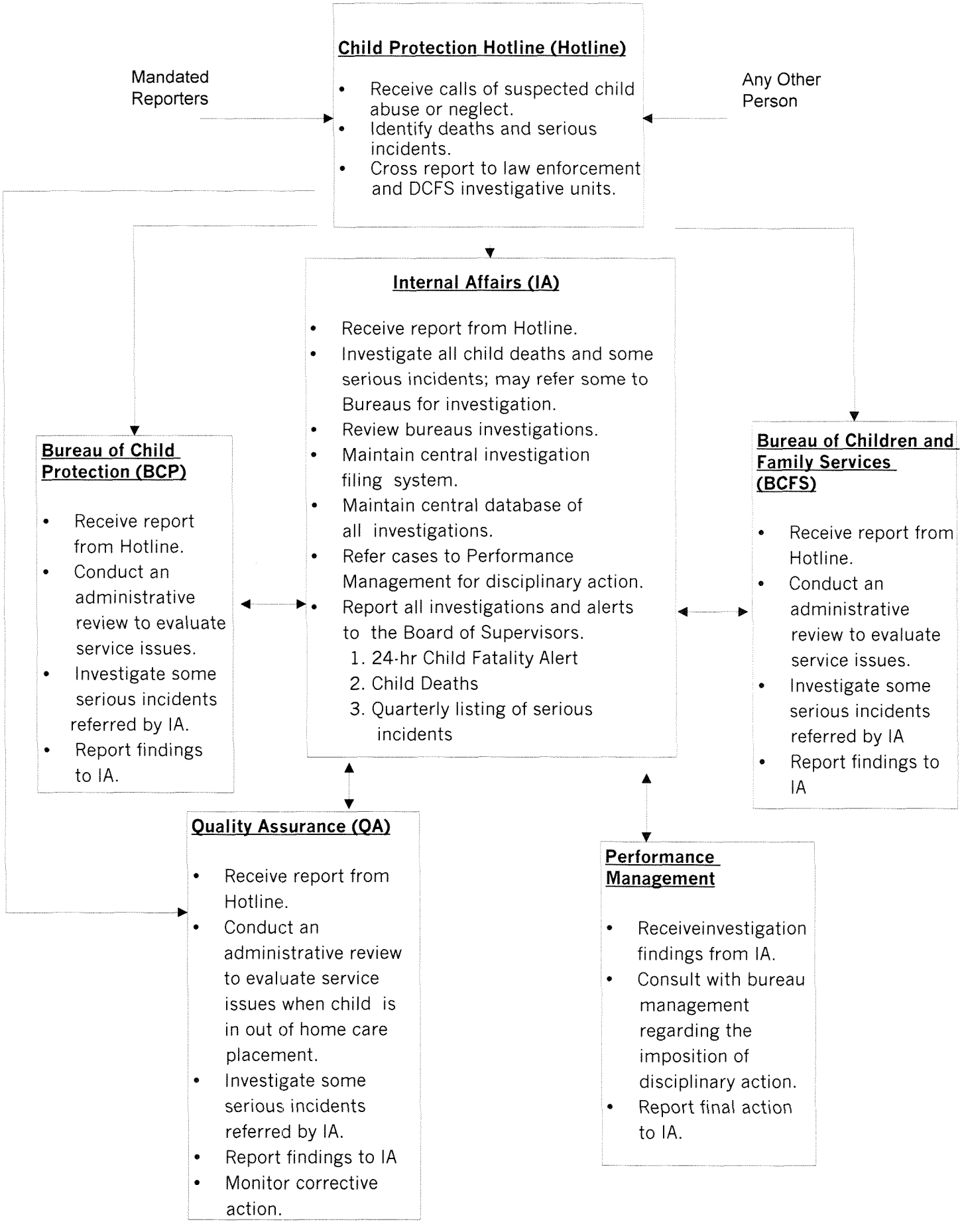
Serious Incident Analyst (SIA)

- Receive report from Hotline
- Identify and gathers facts on child deaths and serious incidents.
- Assist bureaus in administrative reviews.
- Submit serious incident logs to the Board through the Commission for Children and Families.

Quality Assurance (QA)

- Receive report from Hotline.
- Investigate allegations of suspected abuse/neglect by the licensed caregiver and assess the Department's future use of the facility.
- Refer cases to IA, as appropriate, when its investigation uncovers suspected employee misconduct.

Recommended Investigation Model



County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

MARJORIE KELLY
Interim Director

Board of Supervisors
GLORIA MOLINA
First District
YVONNE BRATHWAITE BURKE
Second District
ZEV YAROSLAVSKY
Third District
DON KNABE
Fourth District
MICHAEL D. ANTONOVICH
Fifth District

February 26, 2003

J. Tyler McCauley
Auditor-Controller
525 Kenneth Hahn Hall of Administration
500 W. Temple Street
Los Angeles, CA 90012

RESPONSE TO MANAGEMENT AUDIT OF DCFS' INTERNAL AFFAIRS UNIT

Dear Mr. McCauley:

We have had a chance to review the Management Audit of the Department of Children and Family Services Internal Affairs Unit and I would like to offer the following comments.

We concur with the overall findings of the audit. Our own internal review of the Department's child death reporting and critical incident handling processes has highlighted many of the same issues and challenges. Over the last several months we have been in the process of making improvements in the Department's organizational structure and in processes and procedures in areas related to many of the Internal Affairs functions. As a result we have been moving to correct and address many of the deficiencies that have subsequently been identified in your audit report.

A number of findings and recommendations identified in the audit are in the process of being implemented (as we discussed in our exit conference). We have provided materials and suggested changes in processes and procedures to Mr. Joe Kelly that reflect our Department's actions to date and our willingness to initiate changes that will address the recommendations identified in the audit report.

I would like to express the Department's appreciation to the Auditor-Controller's Office for the highly professional way this audit was handled and we want to thank those involved in its preparation.

Sincerely,

Marjorie Kelly

MARJORIE KELLY
Interim Director

MK:mdd